**** Working Plan ****

Managing Asthma: the Health Care System

Acknowledgements

Planning for Asthma Control in Rhode Island is a program organized by the Rhode Island Department of Health (HEALTH) and the American Lung Association of Rhode Island (ALARI) with a major grant from the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. The program would be impossible without generous contributions of time and in-kind resources from many organizations and individuals in the Rhode Island community and throughout New England.

I. Planning Groups

Many people contributed to this working chapter of the Rhode Island Asthma Control Plan. The contributors worked together in several planning groups, as follows:

The Primary Care Physician Advisory Committee (2 planning sessions): An independent body established to advise the Director of Health on all essential issues pertaining to primary health care in Rhode Island.

Specialty Care (2 planning sessions): An ad hoc group of respiratory therapists, pulmonologists, and allergists convened for planning by the Asthma Control Program.

Managed Care (3 planning sessions): An ad hoc group of representatives from the three major health plans in Rhode Island (Blue Cross/Blue Shield, United Health Care of New England, and Neighborhood Health Plan of Rhode Island) and from Rhode Island Quality Partners.

Participants at the June 9, 2000 Asthma Summit (1 conference workshop): 119 people attending the first Rhode Island Asthma Summit on June 9, 2000 critiqued some of the ideas developed by the three preceding groups, adding ideas of their own for the development of this chapter. Participants included physicians, nurses, respiratory therapists, social workers, pharmacists, public health officials, school officials, representatives of community organizations, and other interested parties. The Rhode Island Department of Health and the American Lung Association of Rhode Island organized the June 9th Asthma Summit with volunteers from many organizations throughout Rhode Island.

Physician Focus Groups: The Asthma Control Program, in collaboration with United Health Care of New England ("UHCNE"), is holding a series of physician focus groups to address issues of asthma management from the physician's perspective. The groups are assembled according to physician specialty, as follows:

- pediatrics and family practice: (one group held)
- pulmonary medicine and allergy/immunology: (one group held)
- general internal medicine: (one group held)
- emergency medicine: (one group planned)

All participating physicians are United Health Care of New England medical providers. From six to eight physicians participate in each group. Membership in the focus groups after the fact (in tapes, transcripts, and summary reports) is anonymous.

Patient Focus Groups: Similarly, the Asthma Control Program, in collaboration with United Health Care of New England, is holding a series of patient focus groups to address issues of asthma management from the patient's perspective. Between four and six focus groups are planned. From six to eight patients will participate in each group. Membership in the focus groups after the fact (in tapes, transcripts, and summary reports) is anonymous.

Participants at the September 22, 2000 Asthma Summit (1 conference workshop): 116 participants at the second Rhode Island Asthma Summit on September 22, 2000 have critiqued this chapter, suggesting modifications. Participants

represented a broad range of professions and organizations interested in reducing the burden of asthma in Rhode Island. The Rhode Island Department of Health and the American Lung Association of Rhode Island organized the September 22nd Asthma Summit with volunteers from many organizations throughout Rhode Island.

The membership of each of the groups listed above (except for those whose anonymity has been assured) is included in Section VIII of this chapter.

II. Coordination

The planning effort that resulted in this chapter has been coordinated with a number of asthma control efforts in Rhode Island, New England, and the country as a whole:

Medicine and Health / Rhode Island: In 1999, many local experts shared their thoughts on asthma control by contributing to a special CME issue of ***Medicine and Health / Rhode Island***, Rhode Island's journal of medicine and public health practice. This effort was the result of a collaboration between the Rhode Island Medical Society and the Rhode Island Public Health Association, with financial support from the American Public Health Association, the American Medical Association, and the Robert Wood Johnson Foundation. The CME issue on asthma, published in July 1999, was co-edited by Charles Sherman, MD, MPH, Associate Professor, Brown University School of Medicine, and Patricia Nolan, MD, MPH, Director of Health. Articles from the CME issue were used as an introduction to the planning sessions described in Part I of this chapter.

The Managed Care and Public Health Collaborative of New England: This group brings together the Health Commissioners/Directors of the New England states with representatives of the major health plans in the region to explore collaborations between public health and managed care. One of four sets of recommendations released by the group in June, 2000 focuses on the management of pediatric asthma, and has been studied and discussed by public health officials and managed care leaders in Rhode Island, to assure conformity between New England and Rhode Island plans for asthma control.

The Providence Pediatric Asthma Coalition: This coalition of community organizations was founded to reduce the burden of asthma on children in the City of Providence, Rhode Island, with special emphasis on inner city children from low-income families. The Rhode Island Department of Health, the American Lung Association of Rhode Island, major health plans, and major health care agencies are all represented in the group. Presently, the coalition is focussing on the Providence Public Schools as a major channel for asthma education and control among the city’s children and their parents. Strong ties between the coalition’s work and the statewide asthma control planning process will assure consistency and augmentation between the two.

Healthy People 2010: This national planning effort has developed ten-year public health goals for the United States. Goals from its chapter on asthma are consistent with the recommendations for asthma control developed in Rhode Island, New England, and the City of Providence. To assure coordination between asthma control efforts in Rhode Island and the nation as a whole, the Healthy People 2010 goals for asthma are proposed as ten-year goals for asthma control in Rhode Island.

III. Brief Synopsis of Asthma Management

Managing asthma is complex. Asthma triggers abound, the control of asthma commonly requires long-term (controller) and short-term (rescue) medication, and the delivery of medication (usually inhaled) requires the use of devices such as inhalers, spacers, and peak-flow meters. To be used effectively, asthma medications must be used at the right times and in varying amounts, depending on the patient's immediate need. To know what to do and when to do it usually requires a written asthma action plan, with contingencies governing the use of medication and back up from physicians and emergency departments. All of this must be managed by the patient in a world that is not asthma-friendly. People in the patient's immediate support group may not understand asthma, its causes, or its management, and probably harbor common misunderstandings about the condition – that people with asthma should not exercise, that the origin of asthma is entirely psychological (therefore suspect), that asthmatics are "wimps." Finally, asthma triggers tend to be much more severe in places where low-income people live, learn, work, and play, placing a disproportionate asthma burden on the very people who are least likely to have the financial resources to cope with it, and creating racial and ethnic disparities in disease burden.

The stakes are high for individuals. When asthma is poorly managed, patients are at risk of activity limitation (sometimes extreme), social ostracism (especially among children and teens), severe asthma attacks (requiring emergency department visits and hospitalizations), even death.

The stakes are high for our state. Based on national statistics regarding the prevalence of asthma, an estimated five-percent of the state's population has asthma, and the prevalence is increasing for reasons unknown. Among families of low income, the prevalence of asthma may be double or triple that of the population as a whole. Children are hardest hit. Because of their social status, children are least likely of all people to be able to control their physical and social environments. Poorly managed asthma takes its toll on schooling, productivity, and health care costs.

To reduce the incidence and severity of asthma and its consequences in our society will not be easy. To do so, we must reduce exposure to asthma triggers, assure access to health care (primary and specialty care), and support patients and their families as they attempt to manage triggers, medications, devices, medical care, lifestyle, and widespread societal ignorance. Problems abound. We must work closely with one another to overcome them.

IV. Problems Identified by the Planning Groups

Many patients do not get adequate education and support. As a result, they do not avoid triggers optimally, and do not use medications, devices, and the health care system properly. They experience unnecessary exacerbation of asthma, leading to avoidable limitations of activity, emergency department visits, and hospitalizations. Long-term exacerbation of asthma may eventually lead to irreversible airway changes, and greater difficulty in managing the condition. Most asthma patients receive health care in primary health care settings. Although primary care providers understand asthma, its causes, consequences, and management, they face many problems in helping patients manage asthma in their daily lives, as enumerated below.

A. Primary care providers find current practice guidelines too complex to integrate easily into the daily practice of medicine. For example, the 1997 guidelines published by the National Heart, Lung, and Blood Institute (NHLBI) is 142 pages long. Most primary care providers are familiar with the overall gist of the guidelines, but not with many of its details. They find it virtually impossible to conform to the guidelines, despite widespread respect for the document as a framework within which to work. Thus, it is generally acknowledged that controller medication, devices such as spacers and peak flow meters, and written asthma action plans (for the use of patients in the daily management of asthma) are underutilized by national standards.

B. Many people with asthma have not been diagnosed with asthma.

C. Some people do not accept the diagnosis of asthma for themselves or for their children, especially those who smoke.

D. Some people with asthma, especially those with severe asthma, would benefit from earlier referral to asthma specialists (although in the recent past, more people have been referred to specialists early in the course of disease).

E. Primary care providers have little time to educate patients during office visits, and less time to answer the many questions which patients may have as they attempt to manage asthma in their daily lives. The health care community as a whole recognizes the impossibility of fully educating patients during office visits to busy primary care providers. This is a system problem experienced by providers and patients, alike. It is not a problem caused by providers or patients. However, opportunities for patient education, especially in the waiting rooms of primary care providers, are lost.

F. Patient education is complicated by lack of a common asthma vocabulary among health plans, community organizations, and public health agencies. This causes confusion among patients, which, in turn, wastes valuable (and scarce) educational resources.

G. Patient education is also complicated by patients' language, literacy, and and computational skills, requiring repetition and reinforcement of simple educational messages over time.

H. Primary care providers cannot keep track of patients' needs for follow-up care. Generally, primary care practices do not have systems to track patient visits or medication use. As a result, patients as a rule see primary care providers too infrequently for optimal asthma management, and valuable indicators of the adequacy of asthma management, which might flag problems as they develop, are unusable.

I. Each health plan has its own guidance, formulary, and reimbursement plan for asthma management. Although the plans may be quite similar in their approach to asthma management, primary care providers find it difficult to keep up with the specifics of each plan, and perceive the whole as complex and inconsistent.

J. Primary care providers encounter barriers to the provision of asthma-related equipment to patients. Providers have described situations in which coverage for equipment has been allowed too late to prevent emergency department visits for asthma. The communication between providers and health plans regarding the need for equipment and its use is poor.

K. Primary care providers have not found a simple and consistent way to communicate with school nurse teachers and other school officials about the needs of their pediatric asthma patients.

L. People who are uninsured frequently get primary care from urgent care centers and emergency departments, where they receive uncoordinated, ad hoc, episodic care.

V. Recommendations of the Planning Groups

Recommendations of the planning groups converged on improving asthma management by better equipping and supporting patients and their primary care providers. Patients need proper education, medication, equipment, and ongoing support. Primary care providers need simplified guidelines, simple and coordinated educational messages for patients, help in tracking patients, and feedback on patient care. Most of the help for patients and providers, alike, must come from public health and community organizations, health plans, and schools.

A. Public Health and Community Organizations

1. Serve as a convener and catalyst for the collaboration of health plans on asthma control projects.

2. Coordinate the asthma control messages given to people with asthma by primary care providers, major health plans, the Rhode Island Department of Health, schools, and other community organizations.

   - Collaboratively select the most important asthma control messages.
   - Encourage consistency in messages.
   - Develop messages to help people who have not been diagnosed with asthma recognize the symptoms of asthma.
   - Ensure all asthma education materials follow NHLBI guidelines, updated to reflect the use of new medications.
   - Ensure that all asthma education materials are written for people of low literacy, in a number of common languages, and in a way which is culturally competent.

3. Develop an asthma control web site containing:

   - Asthma education messages and materials for asthma patients developed in collaboration with major health plans
   - Simplified treatment guidelines for primary care physicians, as developed in collaboration with major health plans
   - Up-to-date, credible links to the asthma literature for physicians
   - Notices of events of interest to asthma patients and physicians
   - Multi-lingual information

4. Promote the web site with an integrated media campaign.

   - Develop a 1-800-telephone hotline (receiving calls in at least two languages - English and Spanish – when it is first fielded).
   - Develop printed materials for distribution to patients in hospitals, physicians' offices, and pharmacies.
   - Recruit Rhode Island athletes to help communicate asthma messages to the public.
   - Coordinate the media campaign with tobacco control media campaigns in Rhode Island.

5. Sponsor primary care provider education for asthma care in collaboration with major health plans.

   - Focus on existing gatherings of physicians.
   - Coordinate with existing activities.

6. Sponsor a widely advertised annual asthma summit to convene all asthma control professionals in Rhode Island with the following foci:

   - Review progress in Rhode Island toward the achievement of *Healthy People 2010* goals for asthma.
   - Identify current barriers to effective asthma management in Rhode Island.
   - Review successful approaches to patient education and support.

7. Explore the certification of asthma educators in Rhode Island prior to the adoption of a national certification program.

   - Follow developments in other states and nationally.

8. Explore the role of pharmacists in the education and support of asthma patients.

   - Work with the University of Rhode Island and pharmacy associations in Rhode Island.

   - Create a brief brochure for distribution in pharmacies that contain standard asthma control messages for Rhode Island.

9. Develop an asthma surveillance system in collaboration with major health plans that measures progress toward Healthy People 2010 objectives for asthma and informs decisions in the health care system.

   - Establish an asthma surveillance consortium with Major health plans and other interested parties.

   - Perform regular surveillance of asthma using statewide surveys, hospital discharge data, and vital records.

   - Publish surveillance reports on the web site, and present surveillance reports at the annual asthma summit.

   - Include an annual asthma report card measuring progress toward Healthy People 2010 objectives for asthma.

   - Share non-confidential surveillance data with Major health plans to help inform policy decisions.

   - Explore the use of Kids Net (a pediatric health information registry maintained by the Rhode Island Department of Health) to record the presence or absence of asthma diagnosis.

B. Health Plans

1. Adopt and promote the use of a standardized asthma practice guideline by major health plans in Rhode Island (based on NHLBI recommendations). The guideline should be written in two distinct sections: adult and pediatric, and must be revised regularly to keep up with current developments in the field.

- Coordinate the distribution of a standardized asthma practice guideline to all primary care providers, asthma specialists, and other professionals working on asthma control in the State.

- Write a user friendly, short summary of the practice guidelines to be included in the distribution of guidelines.

- Collaboratively design and promote the use of a common asthma action plan.

2. Publish a common formulary of approved asthma drugs across major health plans in Rhode Island to avoid discontinuities when patients change health plans, and to help providers prescribe drugs that are reimbursable.

3. Coordinate the asthma control messages given to people with asthma by primary care providers, major health plans, the Rhode Island Department of Health, schools, and other community organizations.

   - Collaboratively select the most important asthma control messages.

   - Encourage consistency in messages.

   - Ensure all asthma education materials follow NHLBI guidelines.

4. Provide feedback to primary care providers and specialists about their adherence to standardized asthma practice guidelines.

   - Major health plans, in collaboration with primary care providers in Rhode Island, will establish statewide asthma quality indicators that measure provider adherence to asthma practice guidelines.

   - Major health plans will provide feedback to providers on their adherence to asthma practice guidelines.

   - Major health plans will investigate the possibility of aggregating health plan asthma data by an independent third party to facilitate more complete performance measurement to providers.

   - Major health plans will promote non-financial incentives to recognize high performing providers within their own plans.

5. Establish stronger communication linkages between health plans and emergency departments. Health plans should share information about emergency department visits with primary care providers as soon after visits as possible.

6. Share asthma case management information when members change health plans.

   - Develop a mechanism for members with asthma to give permission for the transfer of case management information from the old plan to the new plan. Protect the confidentiality of this information.

   - Educate members with asthma about the process to follow to transfer medical information when switching healthcare providers.

7. Hold discussions about the general outlines of benefit structures that optimize the management of asthma.

   - Encourage major health plans to examine benefits structure for barriers and facilitators to effective and efficient asthma treatment.

   - Learn about best practices for asthma benefit structures from published studies.

   - Participate in annual asthma summit sponsored by the American Lung Association and the Rhode Island Department of Health.

8. Explore the possibility of major health plans pooling selected asthma data for statewide asthma surveillance for the Rhode Island Department of Health. Consider using an independent 3rd party to receive and aggregate data.

C. Schools

Recommendations for schools are covered in a separate chapter, "Managing Asthma: the School System."

VI. *Healthy People 2010* Objectives for Asthma

As stated above, this national planning effort has developed ten-year public health goals for the United States. Goals from its chapter on asthma are consistent with the recommendations for asthma control developed in Rhode Island, New England, and the City of Providence. To assure coordination between asthma control efforts in Rhode Island and the nation as a whole, the *Healthy People 2010* goals for asthma are proposed as ten-year goals for asthma control in Rhode Island. The original numbering of *Healthy People 2010* goals for asthma has been retained to facilitate comparisons between Rhode Island, other states, and the nation as a whole:

24-1. Reduce asthma deaths.

24-2. Reduce hospitalizations for asthma.

24-3. Reduce hospital emergency department visits for asthma.

24-4. Reduce activity limitations.

24-5. (Developmental) Reduce the number of school or workdays missed by persons with asthma due to asthma.

24-6. Increase the proportion of persons with asthma who receive formal patient education, including information about community and self-help resources, as an essential part of the management of their condition.

24-7. (Developmental) Increase the proportion of persons with asthma who receive appropriate asthma care according to the NAEPP Guidelines.

24-8. (Developmental) Establish in at least 15 States a surveillance system for tracking asthma death, disability, impact of occupational and environmental factors on asthma, access to medical care, and asthma management.

Add: Increase the proportion of persons with asthma who self-manage asthma effectively. [Identify and use valid and reliable measures of effective self-management.]

Add: Increase the coordination of asthma care among emergency departments, primary care providers, asthma specialists, and health plans.

VII. Next Steps

Two next steps have been suggested: A/ to create a fully organized Asthma Professional Advisory Committee for developing the recommendations of the planning groups, and B/ to build a fully operational surveillance system to support all major asthma control activities in Rhode Island.

A. Develop and support the Asthma Professional Advisory Committee (APAC) as an advisory body to the statewide asthma control program. Build APAC by expanding the Asthma Summit Group, a committee of volunteer asthma control professionals based at the American Lung Association of Rhode Island. The Asthma Summit Group has served as a steering committee for the asthma control planning process thus far.

- Membership: Representatives of the Rhode Island Department of Health, the American Lung Association of Rhode Island, major health plans, primary care providers (including physicians, nurse practitioners, physician's assistants, and nurses in various capacities), specialty care providers, respiratory therapists, pharmacists, school nurse teachers, hospitals, and other interested organizations and professionals. All committees and task forces should be multi-disciplinary.

- Mission:

  APAC will monitor the burden of asthma in Rhode Island, develop policies at the state and local levels to reduce

that burden, and promote those policies at the state and local level.

APAC will monitor and promote the coordination of asthma-related public and professional education in Rhode Island and New England.

APAC will oversee the development and maintenance of an integrated asthma-related media campaign in Rhode Island, including a user-friendly web site for the public.

APAC will plan and convene an annual asthma summit for asthma control professionals and asthma patients.

APAC will appoint sub-committees to discharge ongoing responsibilities for the committee.

APAC will appoint task forces to undertake short-term and long-term projects and to study issues of potential importance for the control of asthma in Rhode Island.

- Staffing: APAC will be supported primarily by staff of the Rhode Island Asthma Control Program based at the Rhode Island Department of Health, supported by staff of the American Lung Association of Rhode Island.

- Subcommittees:

  ✓ Public Education

  Mission: Develop and maintain an integrated asthma-related media campaign in Rhode Island, including a public-friendly web site.

  Develop a common vocabulary for asthma patient education in Rhode Island.

  Develop common messages for asthma patient education in Rhode Island.

  Develop special message packaging for selected populations, including recent immigrants, the elderly, communities of color, and the homeless.

  Monitor asthma education resources throughout the state and nation.

  Duration: Ongoing

  Product: Ongoing media campaign and web site

✓ Professional Education and Support

Mission: Develop and maintain ongoing asthma-related professional education and support programs, including an integrated professional-friendly web site.

Duration: Ongoing

Product: Ongoing, high-quality presence in all relevant professional education channels in Rhode Island, policies that support the provision of high-quality medical care to asthma patients, and web site

✓ Annual Summit

Mission: Plan and convene an annual asthma summit for asthma control professionals and asthma patients.

Duration: Ongoing

Product: Annual asthma summits

✓ Access to Asthma Care

Mission: Monitor health care issues for people of low income with asthma, including those who are elderly, those whose health insurance is Medicaid, those who are uninsured, and those who are homeless.

Advocate for these groups.

Duration: Ongoing

Product: Annual report at asthma summits

- Task Forces:

✓ Guidelines

Aegis: APAC Sub-committee on Professional Education and Support

Mission: Write a user-friendly, short summary of the NHLBI practice guidelines for the management of asthma.

Develop a standard asthma action plan for use throughout Rhode Island.

Develop a plan to distribute the standard asthma action plan throughout Rhode Island.

Plan a system for summarizing asthma patient care information from major health plans for individual providers, using variables relevant to the summary guidelines.

Discuss the general outlines of benefit structures that optimize the management of asthma.

Duration: One year

Product: Short summary of the NHLBI practice guidelines for the management of asthma, including a standard asthma action plan.

Timeline: Draft report to APAC Sub-Cmte 7/2001
Draft aired at annual summit, 9/2001
Final report to APAC 11/2001

✓ Data Sharing

Aegis: APAC

Mission: Explore the use of health plan data for asthma surveillance.

Explore data sharing among major health plans to avoid discontinuities in care when patients transfer from one plan to another.

Duration: One year

Product: Report to APAC.

Timeline: Draft report to APAC 7/2001
Draft aired at annual summit, 9/2001
Final report to APAC 11/2001

✓ Pharmacists

Aegis: APAC Sub-committee on Professional Education and Support

Mission: Study the role of pharmacists in the education and support of asthma patients.

Address issues inherent in pharmacy-based patient education, including privacy and available time.

Study the use of Internet linkages at pharmacies to help patients access the public asthma web site.

Duration: One year

Product: Report to APAC.

Timeline: Draft report to APAC Sub-Cmte 7/2001
Draft aired at annual summit, 9/2001
Final report to APAC 11/2001

✓ Certified Asthma Educators

Aegis: APAC Sub-committee on Professional Education and Support

Mission: Assess the merits of certification for asthma educators.

Study the possibility of reimbursement for patient education.

Duration: One year

Product: Report to APAC.

Timeline: Draft report to APAC Sub-Cmte 7/2001
Draft aired at annual summit, 9/2001
Final report to APAC 11/2001

B. Build an effective asthma surveillance system, based at the Rhode Island Department of Health, but run in collaboration with the American Lung Association of Rhode Island and major health plans, with guidance from APAC and the Centers for Disease Control and Prevention. The asthma surveillance system should be capable of measuring Healthy People 2010 goals, as well as policy objectives developed by APAC for the Rhode Island Asthma Control Program.

VIII. Membership of the Planning Groups

Primary Care Physician Advisory Committee

David Carter, MD (RI Medical Society) Anthony L. Cirillo, MD (RI ACEP)	Vincent Hunt, MD (Hospital-Based) Martin Kerzer, DO (RISOPS)
Colleen Cleary, MD (RI Medical Society) Russell Corcoran, MD (RI ACP) Michael Fine, MD, Chair (Private Practice)	Victor Lerish, MD (AAP) James E. Monti, Jr., MD (Private Practice) Donya Powers, MD (AFPRI)
Ellen Gurney, MD (Community Health Ctrs) Scott R. Hanson, MD (RI Medical Society) Jennifer Hosmer, MD (ACOG)	Richard Smith, MD (Private Practice) Patrick Sweeney, MD (ACOG) Ivan Wolfson, MD (Travelers' Aid)

Ad Hoc Specialty Care Group

Sidney Braman, MD (RI Hospital)	Catherine Kernpe
Peter Karczmar, MD (Private Practice)	Cheryl LaFreniere
Annie Parker, MD (Memorial Hospital of RI)	Jayne Matoian, RRT
Charles Sherman, MD (Private Practice)	Ellen Perz
Eliza Beringhause, RRT	Mark Scanlon
Karen Carlton	Laureen Sheehan
Lorri Charpentier	Kathy Short
Teri Cicero	James Smart, RRT
Mark Cooper, RRT	Susan Venezia, RRT
Jodys Ann Cowdin	Deborah Walsh, RRT
Linda Dangelo	Jeanne D’Agostino, CRT
Angela Gasparri	Crystal M, RRT

Ad Hoc Managed Care Group

Brenda Buden (Blue Chip / Blue Cross Blue Shield)	Renee Rulin, MD, MPH (Neighborhood Health Plan of RI)
Paul Davis, MPH (Blue Chip / Blue Cross Blue Shield)	Sharon Marable, MD, MPH (RI Department of Health)
Julie Johns (Blue Chip / Blue Cross Blue Shield)	Barbara Casey, MPH (RI Quality Partners)
Tony Shola (Blue Chip / Blue Cross Blue Shield)	Ed Westrick, MD (RI Quality Partners)
Yvette St. Jean (Blue Chip / Blue Cross Blue Shield)	Jeanne Ehmann, RN, MS (United Health Care of NE)
Susan Wien-Gebhardt (Blue Chip / Blue Cross Blue Shield)	Melissa Nickel (United Health Care of NE)
Dale Rogoff Greer, RN, MPH (Neighborhood Health Plan of RI)	Deborah O'Connell (United Health Care of NE)